HHA PPS MAILBOX QUESTIONS

VOLUME I: DECEMBER 2000 AND JANUARY 2001 – Batch 2

The questions below, which in some cases have been paraphrased, were sent to: *HHPPSQuestions@HCFA.gov* during the period referenced above. It is our intention to continue to aim to answer question that come into that mailbox in monthly batches, and post those answers at: *www.hcfa.gov/medlearn/refhha.htm.* For example, a first batch of questions was pulled from the mailbox prior to February 1, 2001, though the initial set of questions and answers derived from that from that were not posted until March 2001. In cases where time was needed to consult internal experts, multiple batches of answers may be released under the same Volume number (same time period or month). Note that questions without broad applicability have been/will be answered/referred individually.

Questions are grouped by topic and not repeated. However, each batch of questions will be listed by topic in order at the beginning of each batch of answers, and a table of cross-references will follow.

List of Home Health Prospective Payment System (HH PPS) Billing Questions, Volume I, Batch 2:

HH PPS and General Policy 1-6:
Home Health (HH) Consolidated Billing: 1, 2, 3
Mediport Flushes: 4
Trauma Diagnosis Codes: 5
Cost Reports: 6, 7

HH PPS Claim Elements 8:
Total Line Item Charges: 8

HH PPS Billing Questions Cross-reference, Volume I, Batch 2:

Home Health (HH) Consolidated Billing: 1*, 2*, 3*
Mediport Flushes: 4*
Trauma Diagnosis Codes: 5*
Cost Reports: 6*
Lowest of Cost or Charges: 6*, 7
Total Line Item Charges: 8*

Other Topics:
Medicaid: 1
Dual Eligibles: 1
Non-routine Supplies: 1
Durable Medical Equipment (DME): 2
Enteral Nutrition: 2

*** = question appears under this topic below**

General Acronyms

The following acronym may not be spelled out/explained above or elsewhere in this document:

HH = Home Health
HHA = Home Health Aagency
HCFA = Health Care Financing Administration, the Federal Agency administering Medicare
HIPPS = Health Insurance PPS, a code representing a PPS payment group on a Medicare claim, placed in Form Locator 44
HCPCS = HCFA Common Procedure Coding System, individual codes representing medical services or items in Form Locator 44 of Medicare claims
IPS = Interim Payment System, the legislated system for paying cost-reimbursed home care under Medicare from 1998 until HH PPS.
OASIS = Outcome Assessment Information Set. The standard assessment instrument required by HCFA for use in delivering home care.

VOLUME I, Batch 2, HH PPS Billing QUESTIONS and ANSWERS

HH PPS and General Policy, Questions 1-5:

Home Health (HH) Consolidated Billing, Questions 1-3:

Q1. Is it correct that a home health agency must also provide all routine and non-routine supplies at no cost to state Medicaid patients? The director of our agency heard this at an industry meeting, but we have not seen anything in writing.

A1. An HHA only has to provide the medical supplies that are subject to the consolidated billing provision to dually eligible patients, that is, patients who can receive both Medicare and Medicaid.

Q2. We are to admit a patient today with a tracheotomy and tube feedings. He requires eight cans of Isocal HN daily. The discharge planner told the patient's daughter that the durable medical equipment (DME) company that supplied the pump and tracheotomy mister, etc., would supply the Isocal. Reportedly, the DME supplier told the daughter that the home health agency is responsible for supplying the nutrition via tube feedings. Which is true-- can the DME be reimbursed for enteral nutrition, or does the home health agency have to supply the nutrition? Aren't tube feedings "nutrition", just like food for everyone else? Medicare doesn't pay for people's food-- then what is the reasoning behind paying for the Isocal (or whatever)?

A2: Enteral nutrition is not included in the home health prospective payment rate. The DME company can be reimbursed for enteral nutrition.

Q3. There are two products that are enzymatic wound healing and/or debredement ointments-- Regranex and Panafil—ordered for a home health patient. Are these products, that are physician prescribed topical ointments, included in consolidated billing, and if so how can an agency determine this? [***ANSWER REVISED July 3, 2001***]

A3: **Regranex and Panafil are prescription drugs that are self-administered. They are not covered by Medicare. They are not subject to consolidated billing.**

<u>Other HH PPS Policy Question, 4-5</u>:

Q4. Are visits to a homebound client for the sole purpose of a monthly Mediport flush a covered service under the Home Health Benefit?

A4. If the physician is actively prescribing medication to be administered via the Mediport, then the answer to this question is "yes". If the physician is not actively prescribing medication to be administered via the Mediport, then the answer is "no". By "actively prescribed", we mean a period of approximately three months.

Q5. We are having problems with the use of trauma codes on our OASIS. We understand that we have to be very careful in their use so that Medicare is not wrongly charged for something that workman's comp or an auto insurance company will pay. What our real problem is, though, is surgical incision codes. We believe ICD9 Manual describes these as trauma codes. Can we use these codes as diagnoses supporting home care if a surgical incision is something we are assessing? Should we only use a surgical code as a secondary diagnosis with the problem that caused the patient to have the surgery as the primary? We fear we will receive denials for claims where we used 800 series diagnostic codes, because we were unaware of the information above at the time

of submission, and that, if used, an explanation should accompany the use. Please help us to understand this more clearly, mainly the use of surgical incision codes.

A5. Care for surgical incisions is NOT coded with a trauma code. Also, OASIS does not allow surgical codes (which are not diagnosis codes) or V-codes. V-codes would be the most appropriate in these cases, but cannot be used on OASIS. Currently, OASIS instructions for surgical wound cases are to code the underlying or medically relevant diagnosis.

Cost Reports, Questions 6-7:

Q6. Assume an agency has three months under IPS and nine months under HH PPS. At the end of the three-month cost report period, the internally computed cost per visit exceeds the current charges. If the agency increased the per visit charges for the next nine months, would the increase impact the lower of cost or charges (LCC) calculation of the first three months? Or, will the charges for the three-month IPS period be measured against the aggregate cost per visit of a twelve-month period? Is it too late to impact aggregate charges, once the IPS period has ended? Then is the only recourse for the agency is to reduce cost per visit?

A6. To answer the first part of your question, no, the first three months of the cost reporting period under IPS subject to LCC will not be impacted by an increase in the per visit charges for the last nine months of the reporting period, because only the actual charges imposed for services rendered for the first three months are used in the comparison.

To answer the second part of your question, the charges for the first three months of the reporting period will not be directly compared with the aggregate cost per visit for the entire twelve month period, but the aggregate cost per visit is used in determining the cost (based on the first three months of visits) that will be compared to the corresponding charges imposed. Using your example, the "internally" computed cost per visit for the first three months under IPS (which exceeds the current charges) is not used exclusively to compare IPS costs to IPS charges in the cost report, but rather the aggregate cost for the entire fiscal year is divided by the total visits for the entire fiscal year resulting in the average cost per visit, which is multiplied by the number of visits completed for the first three months of the reporting period.

In your example for the first three months of the reporting period subject to IPS, the first three months of aggregate cost (as described above) is compared to the first three months of the aggregate cost per visit limit, and also to the first three months of the aggregate per beneficiary limit (based on the unduplicated census count for the first three months). The least of these three amounts becomes the cost that is compared to the corresponding charges imposed (for the first three months) in the application of LCC. A critical element of cost reporting is the statistical averaging

of costs in arriving at reasonable cost determinations. As such, the cost report does not calculate multiple costs per visits within in one reporting cycle (fiscal year).

Impacting aggregate charges will have no affect on the comparison because, as previously mentioned, only the actual charges imposed for the first three months will be used in the comparison. From a cost reporting perspective, it does appear that a reduction the average cost per visit for the entire fiscal year may reduce the impact of transitioning from IPS to HH PPS, given the procedure employed in the calculation average cost per visit.

Q7. I would really appreciate some clarification regarding the application of the lower of costs or charges (LCC) rule in HH PPS. I have received verbal reassurance from several reimbursement experts in the state of Illinois that LCC will NOT apply in the HH PPS environment. One of them tells me that she specifically asked the question of HCFA at one of the workshops. However, it does not appear to be specifically stated as such in the final rule. There is only vague language about a "system replacing IPS...." which is the nearest I can come to finding anything that implies LCC will go away.

A7. LCC is only applicable to services reimbursed on a cost basis. After the implementation of HH PPS (services on or after 10/1/2000), only one service under the home health benefit, osteoporosis drugs and its administration, will remain cost reimbursed, and accordingly subject to LCC. After 10/1/2000, only the actual cost of the osteoporosis drugs and its administration are compared to the actual charges imposed for such services in determining reasonable costs. Except for durable medical equipment, which is reimbursed according to a fee schedule, all other home health services are reimbursed under HH PPS, as part of an episode payment, and are not subject to LCC. HH PPS payments are considered payments in full and never subject to LCC.

HH PPS Claim Elements, Question 8:

Total Line Item Charges, Question 8:

Q8. I have a question about UB-92 Claim Form Locator 47, the “Total Charges” field, particularly for charges with "no cents". At a RHHI workshop in the summer of 2000, I believe we were told the following:

> Under HH PPS for the final claim, for FL 47, all charges for home health services with 15-minute increment HCPCS procedural codes (G0154, G0156, etc.) should have no cents in this column. For instance, the charge for a skilled nursing visit may be $150.00, not $150.64.

Is this understanding correct? If so, where is it documented?

A8. Apparently, there was a misunderstanding, since you may continue reporting the charges for these procedures with cents as you did before PPS. We contacted

the RHHI in question, and they confirmed that their training did not intentionally seek to tell providers they could not submit charges with cents, but that because many of their examples of charges in training did not contain cents, some confusion may have ensued.